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The Double Bind of School Nurses and Policy Implementation: Intersecting the *Street-Level Bureaucracy* Framework and Teaching Sexual Health Education.

Permalink

<https://escholarship.org/uc/item/35k4z293>

Journal

The Journal of school nursing : the official publication of the National Association of School Nurses, 37(4)

ISSN

1059-8405

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Publication Date

2021-08-01

DOI

10.1177/1059840519868764

Peer reviewed

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The Journal of School Nursing
1-12
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DOI: 10.1177/1059840519868764
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Abstract

As described in the Framework for 21st Century School Nursing Practice, school nurses bridge the realities of health and education policy within the school community every day. This role is inclusive of helping teach sexual health education (SHE) to students. We were interested in characterizing how school nurses navigate requirements of health education policy to provide their students with the SHE content that they need. Using data from a larger study, we organized a subset of school nurse data within the street-level bureaucracy framework to better understand the many challenges school nurses face in implementing SHE policy. School nurses' involvement in SHE policy implementation was congruent with characteristics of the framework. This included using their professional discretion to manage dilemmas, working with inadequate resources, unclear policy expectations, lack of support, and ambiguous policy goals. Trusted relationships with teachers and students helped school nurses with their SHE policy implementation responsibilities.

Keywords

sexual health education, school nursing, street-level bureaucracy, policy implementation

School nurses are advocates and specialists in school health and support evidence-based practice (National Association of School Nurses [NASN], 2017b). As such, they inhabit two separate policy worlds: education and health. While different statutory and regulatory systems govern each of these policy worlds, school nurses must bridge both. As part of the *Framework for 21st Century School Nursing Practice*, school nurses are encouraged to use their knowledge and experience to take on leadership roles in policy development and implementation related to health education, health equity, health services, and programs at the local, district, state, and national levels (NASN, 2016). Given their commitment to their schools, students, families, and communities, school nurses have opportunities to engage in the development and implementation of local policies related to health education.

The objective of this article was to describe the role of school nurses in the implementation of policies related to health education in schools, more specifically, sexual health education (SHE). SHE policy is but one of many policies that bridge the spectrum of health and education policy that many school nurses find themselves responsible for implementing. However, school nurses' perspectives as policy implementers are largely absent in the literature on school health. We use the *street-level bureaucracy* framework

(Lipsky, 2010), a theoretical framework used to describe how individuals on the front lines of public service implementation policy, to better understand the multiple ways in which school nurses are involved in implementing SHE policy. To illustrate these points, we present an analysis of a subset of data from our study about SHE and factors influencing SHE policy implementation in public secondary schools (Dickson, Parshall, & Brindis, in press).

Background

Policy Implementation

Policies enacted through legislation or executive order generally define a problem or objective and specify the

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organizations responsible for carrying out the policy. Details of policy implementation are commonly the responsibility of the agencies charged with executing and overseeing those efforts (Mazmanian & Sabatier, 1989). Models of policy implementation tend to reflect either a top-down perspective (that of the policy developers concentrating implementation “down” to the individuals or populations to whom the policy is directed) or bottom-up perspective (that of individuals responsible for carrying out daily policy directives and who often interact with individuals for whom the policy may be concentrated; Hill & Hupe, 2014).

The Street-Level Bureaucracy Theoretical Framework

Lipsky (2010) created the term *street-level bureaucrat* (SLB) to characterize individuals engaged in the front lines of policy implementation efforts, with a bottom-up implementation perspective. These frontline individuals have the most direct engagement with the public and have varying degrees of discretion about how to implement a policy. What is implemented on the ground level might differ significantly from what the original policy makers and planners contemplated. According to Lipsky (2010), SLBs commonly work in organizations in which heavy workloads, limited formal supervision, inadequate resources, and an ever-increasing demand for services are the norm. Thus, frontline workers (in this case, school nurses) might have to interpret or reconcile vague or conflicting policy objectives and expectations with professional standards and personal beliefs due to those constraints.

SLBs are not in a position to choose their clients or stakeholders. They frequently lack the resources and authority to control the outcomes or quality of their work. Yet at the same time, they can find themselves as a public face of their organization and the policies for which their organization is responsible for implementing (Gilson, 2015; Lipsky, 2010). As such, SLBs often experience ethical dilemmas between their own ideals of what they believe they should be doing, the realities of the organization within which they work, and the authority and policies that direct them. Sandwiched between the pressures coming from their employing agency and the clients they serve, SLBs attempt to manage and exercise varying degrees of discretion and autonomy to cope with conflicting demands to meet policy objectives. As these actions occur concurrently with these professionals’ efforts to hold onto their ideals, the day-to-day decisions of SLBs effectively become the policy (Gilson, 2015). How these decisions are made and how competing demands are prioritized reflect the structure and culture of the organization and the authority, ideals, and creativity of individual SLBs (Brodkin, 2012; Rigby, Woulfin, & März, 2016).

There are many examples of SLBs in the literature, including judges (Biland & Steinmetz, 2017), police officers (Oberfield, 2012), social workers and other social service

agency personnel (Ellis, 2011), public sector hospital personnel (Thomas & Johnson, 1991), physicians (Gaede, 2016), case managers (Swanson & Weissert, 2017), teachers (Hohmann, 2016; Taylor, 2007), and school personnel (Barberis & Buchowicz, 2015; Robert, 2017). The SLB framework has been applied to nurses working in hospitals (Hoyle, 2014), clinical diabetic nurse educators (Visekruna, McGillis Hall, Parry, & Spalding, 2017), and in community or public health settings (Bergen & While, 2005; Hughes & Condon, 2016; Walker & Gilson, 2004). However, the SLB framework has not been applied specifically to the work of school nurses.

The School Nurse as SLB

SLB characteristics (Lipsky, 2010) are evident in the work and school environment of school nurses. As licensed professionals, school nurses exercise professional autonomy and discretion commensurate with their education and experience (NASN, 2017b). They provide and manage direct health services to students, coordinate school health priorities with other school staff, and communicate directly with students, families, and the larger community. However, the resources at the disposal of the school nurse are frequently unpredictable, varying from school year to school year, often reflecting competing local and state priorities and concomitant resource allocation or designation. The school nurse is often the only health-care provider within the school walls, operating as the health expert for students and staff. School nurses often practice without direct supervision in their immediate work environment, using their discretion to respond to the ongoing needs of students, staff, and community, according to their professional judgment. They might face professional dilemmas and ethical challenges as they strive to balance the complex health needs of individual students with the wellness needs of the larger school population.

Although not all school nurses participate in the planning or delivery of health education, school nurses often collaborate with other school staff in deciding how and when students receive health education and what topics are covered (Borawski et al., 2015; Brewin, Koren, Morgan, Shipley, & Hardy, 2014; Hayter, Owen, & Cooke, 2012; Jackson, 2011; McRee, Madsen, & Eisenberg, 2014; Westwood & Mullan, 2009). More than 20 years ago, Bradley (1997) identified five primary health education roles fulfilled by the school nurse that remain true for many school nurses today: teaching individual students, providing classroom instruction, participating in curriculum planning committees, sharing resources with teachers, and modeling health-promoting behavior. However, school nurses might be less cognizant of the role they play in the implementation of state and local policies related to their practice that were developed in legislative and regulatory environments far from their workplace environment.

School nurses offer valuable expertise in planning the content and delivery of health education and health

promotion efforts (Cheung et al., 2017; NASN, 2017b). Teachers have reported stronger levels of satisfaction when a full-time school nurse served on their school campus, likely because of the multiple roles and various services they provide (Biag, Srivastava, Landau, & Rodriguez, 2014). Although there might be commonalities among many of their primary responsibilities, the roles of school nurses in the delivery of health education can vary widely from one district or school to another (Hoekstra, Young, Eley, Hawking, & McNulty, 2016).

SHE Policy

SHE is an essential part of health education offered by schools and is a content area school nurses might be asked to teach. When it is comprehensive in content, evidence-based, age-appropriate, and medically accurate SHE is effective in increasing protective sexual behaviors (e.g., delaying first sexual encounters, using condoms and birth control) and reducing risky behaviors (e.g., early sexual encounters, multiple sexual partners, not using condoms or birth control) associated with adverse adolescent health outcomes, such as unintended pregnancy and sexually transmitted infection, including HIV (Chin et al., 2012; Lindberg & Maddow-Zimet, 2012; Stanger-Hall & Hall, 2011). Comprehensive SHE in school settings has been shown to have broad support from parents (Barr, Moore, Johnson, Forrest, & Jordan, 2014; Kantor & Levitz, 2017; Millner, Mulekar, & Turens, 2015) and is supported by many professional health and education organizations including the NASN (2017a), American Academy of Pediatrics (2016), National Education Association (2017), American Public Health Association (2014), and School-Based Health Alliance (2015). It is an explicit objective of Healthy People 2020 (FP-12; Office of Disease Prevention and Health Promotion, 2015) and is one of the seven health topic priorities in the 2017 School Health Index policy and programs assessment tool for middle schools and high schools (Centers for Disease Control Prevention [CDC], 2017). However, SHE is not consistently offered in every state (Landry, Darroch, Singh, & Higgins, 2003; Lindberg, Maddow-Zimet, & Boonstra, 2016), and fewer than 40% of high schools teach sexual health-related topics recommended by the CDC (Brener et al., 2017).

School nurses frequently teach SHE content or are invited by the teaching staff to be the SHE content guest speaker (McRee et al., 2014), and school nurses can be effective instructors of SHE content (Borawski et al., 2015). To better understand how school nurses navigate the nuances of teaching SHE and implementing SHE policy, we analyzed the school nurse responses from the original study and tested the utility and applicability of the SLB framework to the role school nurses reported in the implementation of SHE policy.

Method

The sample for this analysis was from a larger study (Dickson et al., in press), recruited from a convenience sample ($N = 122$) of school nurses, teachers who taught health education, and administrators in New Mexico public secondary schools. The sample represented a mix of urban and rural communities (New Mexico Department of Health, 2013), and school nurses constituted a majority of the sample (52%). The University of New Mexico Health Sciences Center Human Research Protection Office approved the study as an exempt study.

Measures

With permission, we used a survey instrument originally developed for a similar study in California (Combellick & Brindis, 2011). We piloted the original survey instrument with a small group of New Mexico school nurses, health educators, and school administrators (none of whom participated in the final study) and SHE experts to assess content validity. The original interview questions were changed to include 67 structured questions and 37 open-ended questions that covered SHE content (what is being taught), delivery (who is teaching the content and how), and policy understanding and implementation. Not all participants had the opportunity to answer every structured question due to branching logic in the survey, and some structured questions were followed by optional open-ended questions.

Procedures

The survey was administered via phone interviews between August 2016 and January 2017, with participants answering questions based on their perspectives, work experiences, and local practices. When a participant indicated that prior approval was needed for their participation, we obtained approval from their district. After obtaining informed consent, semi-structured phone interviews were conducted by the nurse coinvestigator with school nursing experience. Data were collected directly into an encrypted computer in a secure, online database (Harris et al., 2009). A US\$20 gift card was mailed to participants after the interviews. No participant contact information or links to their school or district were maintained after the interview was completed.

Data Analysis

The survey data were downloaded into SPSS Statistics for Windows, Version 23 (IBM, Armonk, NY), for descriptive, statistical analysis, and the open-ended responses were condensed for common areas of participant emphasis. The SLB framework was used to organize school nurse responses to test the applicability of the framework to how the nurses explained their roles in SHE policy implementation.

Table 1. School Nurse Participants by School Level and Geographic Distribution.

	<i>n</i>	%
School environment (not mutually exclusive)		
Middle school	13	22
High school	23	37
Both middle and high schools	23	37
Other type of environment	3	5
Urban/rural ^a		
Metropolitan	13	21
Small metropolitan	10	16
Mixed metropolitan/rural	25	40
Rural	14	23

Note. *N* = 62.

^aNew Mexico Department of Health (2013).

Results

Sixty-three school nurses participated in this study. As illustrated in Table 1, approximately one fifth (22%) of the participants reported working in a middle school and slightly more than a third reported working in a high school, exclusively (37%). Thirty-seven percent worked in middle schools and high schools. The remaining 5% worked in a setting that did not fall into one of those categories (e.g., kindergarten through 12th grade, an alternative high school, or multiple districts or school types). Twenty-three percent worked in rural communities, 40% in mixed metropolitan/urban areas, and 37% in metropolitan or small metropolitan counties.

While 86% of the school nurse participants reported that SHE was taught at their school(s), only 32% reported having knowledge of a district policy for teaching SHE. Most of the participants (90%) indicated that SHE content was taught in multiple grades, most commonly in a health class (75%). Additionally, more than one type of instructor was teaching SHE (most commonly health teachers, school nurses, and external organizations/guest speakers) in most (95%) of the schools where participants worked. However, the study found that school nurses in rural communities reported teaching SHE (62%) more often than nurses in urban communities (26%).

Forty-one percent of school nurse participants reported receiving either support or encouragement or negative pressure from various groups when teaching SHE. Examples of support or encouragement included positive communication from other staff and administration, prioritization of SHE in school, feeling comfortable when openly addressing community concerns about SHE, and being allocated time to teach SHE content and to respond to student questions and concerns. Negative pressure for teaching SHE reported from participants often included being directed to remove essential SHE content that was considered controversial, lack of support (inadequate time or resources to teach SHE), and feeling unsupported by other school staff or administration when SHE was challenged by parents or community members.

A comparable number of participants said they believed that state policies supporting SHE were clear and understandable (46%), while 42% reported they were not sure/did not know and 12% said the policies were not clear. Participants acknowledged that accountability for teaching to SHE policy requirements was problematic. In particular, participants expressed concern about a lack of evaluation regarding the effectiveness of SHE education and the monitoring of adherence with state SHE policy.

As shown in Table 2, participants' descriptions of their roles in implementing SHE policy parallel characteristics of SLBs and the common issues faced by implementers in a SLB work environment. For example, school nurses described the critical importance of trusted relationships with students, staff, and administration; of being engaged and accessible to students and school staff about SHE; and the chronic lack of authority and resources to decide how to implement SHE policy. A defining characteristic for SLBs is the importance of maintaining trust with clients, when using their discretion to implement unclear policy. SLBs also struggle with chronically underresourced responsibilities and with little authority to make the decisions necessary to assure the success of a policy. This lack of authority for SLBs becomes even more difficult when they believe it is necessary to dilute policy impact when faced with additional organizational pressures. School nurses described the tension between pressure from both administration and community to limit SHE content required by state policy. School nurse participants reported concerns that their role in SHE policy implementation might reflect negatively on their employee evaluations.

Participants also identified and described policy solutions, strategies, and support needed from local and state policy makers to better implement SHE policy, as displayed in Table 3. These consist of the need for oversight and accountability for SHE policy implementation, clarity of policy requirements for local districts and schools to clarify SHE content, supporting curriculum recommendations to meet policy requirements, and training for all staff (teaching and nursing) responsible for teaching SHE. These recommendations are lessons garnered through their roles as SLBs and frontline implementers of policy.

Discussion

Findings from this study illuminate the many pressures and dilemmas that confront school nurses as they engage in efforts to implement SHE policy. Responses of the participants were consistent with several defining characteristics of SLBs (Lipsky, 2010; Table 2). School nurses operate as SLBs working directly with the public (students, parents, larger community), often with inadequate resources, ambiguous expectations pertaining to policy goals, and unclear performance measurements (Gilson, 2015). Inadequate resources reported by participants included out-of-date teaching materials, inadequate class teaching time, and

Table 2. Examples of Qualities and Characteristics of Street-Level Bureaucrats (SLBs) and School Nurses (SNs).

SLB Qualities/Characteristics ^a	Examples of SNs Responses Consistent With SLB Qualities/Characteristics	SN Quotes
1. SLBs are engaged in front lines of policy implementation efforts and have the most direct engagement with the public face of public policy at the local site level.	<ul style="list-style-type: none"> • Open, honest relationship with students. • Being available to students and community after class for questions and referrals for health care, if needed by students. 	<p>“They know they (students) can come ask questions, and we will help them.”—rural middle/high SN</p> <p>“We try to be very supportive of parents who are uneasy.”—urban middle SN</p>
2. Importance of trust in using discretion; trust for SLBs includes professional and public trust to discern the importance of treating all equally, yet making reasonable and flexible decisions on how to implement policy.	<ul style="list-style-type: none"> • Trusted relationships with students, teachers, administration, and parents were critical to be able to teach SHE. • Informed parents support teaching SHE in school. 	<p>“I think teachers and nurses can work together.”—urban middle SN</p> <p>“The teacher really shoulders the responsibility for all the health education”—rural middle/high SN</p> <p>“We need resources, please! They can support us working together, so we don’t reinvent the wheel each time”—rural middle/high SN</p>
3. SLBs work in organizations with heavy workloads, chronically inadequate resources, and ever-increasing demand for services.	<ul style="list-style-type: none"> • Only one SN for entire district. • Lack of support to replace outdated teaching materials, supplies, and curriculum challenges their effectiveness. • Need time in schedule for nursing and teaching demands, to organize content to cover topics. • Only permitted to teach one SHE class and no follow-up classes. • Supportive state department of health (public health nurse, health educators, school health nursing advocates) available to help assure that SHE is taught and a more acceptable external resource to the school district is available. • Having a school-based health center available to help teach SHE content and for student referrals. • Having behavioral health support for student referrals. 	<p>“... they can make all of the policies they want, but if you don’t have resources in the schools, it doesn’t matter. Teachers already have so much to teach, nurses already have so much they do. Stop making policies asking for more to be done unless you are going to support the schools with ways to do it.”—urban middle/high SN</p> <p>“Nurses have been a huge advocate for this.”—urban high SN</p> <p>“I’m at 2 districts, so it’s hard to coordinate this.”—rural middle SN</p> <p>“Having a counselor or a social worker, which is really important if the students are triggered in class... they have that mental health support.”—urban high SN</p>
4. Lack of resources and authority to control outcomes or quality of their work dilutes the effectiveness of SLBs, when confronted with pressures preventing their ability to function effectively.	<ul style="list-style-type: none"> • Exclusion of SNs in SHE planning/discussions limits their effectiveness in implementation. • Ethical conflict when district/administration requires SNs to teach abstinence-only content (which is not consistent with state policy) or prohibit teaching about pregnancy, birth control, condoms, or homosexuality. • Lack of adolescent health care and confidential services to refer students in rural communities (health-care provider shortage areas). 	<p>“Limited by the time I was given, pressured not to cover material.”—rural middle SN</p> <p>“Generally speaking if you mention anything about sex, the conversation ends.”—urban middle/high SN</p> <p>“We have limited access to any type of outside reproductive health care... Students have to travel 90 miles. I have to figure out how to get them to the ER, or another town.”—rural middle/high SN</p>
5. Performance measurement related to policy responsibilities is difficult, when there are conflicting standards.	<ul style="list-style-type: none"> • Teaching health education is not consistently described in SNs’ job description or part of their performance evaluation. • Concerns of negative evaluations if SNs teach comprehensive SHE content. 	<p>“I have to be very careful what I tell them (students) and where I send them, and follow the guidelines. You have to be careful to keep your job. I have guidelines I can’t cross.”—urban high SN</p>

(continued)

Table 2. (continued)

SLB Qualities/Characteristics ^a	Examples of SNs Responses Consistent With SLB Qualities/Characteristics	SN Quotes
6. SLBs do not choose their clients, which can place them in a position of limited power for themselves and their clients.	<ul style="list-style-type: none"> • SNs must balance all of student and staff health needs, in addition to SHE education. • SN responsibilities are more difficult when there is a lack of trust with students or in environments in which students do not feel safe. • SNs are often only health-care provider and health expert/resource in school for students, staff, families, and community. 	“I’m one nurse for several small districts. Between travel and nursing, it is hard to teach, but we don’t have a health teacher.”—rural middle SN
7. Absence of clear policy language is a frequent pattern within the work of SLBs; this ambivalence creates space for individuals to become SLBs.	<ul style="list-style-type: none"> • SNs feel state-level SHE policies were unclear or were not sure/did not know. This lack of clarity elevates need for SN to help interpret policies. • Lack of policy direction from district and school administrators regarding SHE. • Supportive state policy language allows for classroom discussion of sexual health and student risk behavior. • Challenging when district policies contradict state policies (e.g., when they require parental signature to attend class with SHE content, or instead of a requirement, the course is considered an elective covering SHE content). 	<p>“When it comes from the district level, what they say and don’t say affects conversation. We need training with administration at schools . . . just so they understand the importance.”—urban middle SN</p> <p>“When the law states we have to mandate it; it makes it easier.”—rural high SN</p> <p>“The laws are understandable, but it’s about implementation of the law. The law needs to be a living document or why is it even there. It’s only as good as we use it.”—rural middle/high SN</p>
8. Experience ethical dilemmas between their own ideals, realities of the organizational power dynamics, policies that direct them and exercise discretion, and autonomy to cope with conflicting demands (meet policy objectives, while holding onto their ideals).	<ul style="list-style-type: none"> • Powerful, political, and religious groups control school board, oppose implementing policies supportive of comprehensive SHE, oppose contraception and teaching of LGBTQ content, and push for abstinence-only content for all students. • Incorrect information among community members/parents regarding what comprehensive SHE content covers (e.g., teaching SHE promotes sexual activity). • Community discussion is needed about adolescent sexual behavior statistics, adolescent health outcome data, and evidence-based interventions to improve poor health outcomes data. 	<p>“We aren’t allowed to talk to students about birth control and condoms. Our school district has been very abstinence based.”—rural middle SN</p> <p>“The administration/district thought teaching it will make the kids want to have sex. The community is very religious; the parents are not talking to their kids (about sex).”—rural high SN</p> <p>“Parents want us only to talk about abstinence.”—urban high SN</p>

Sources. ^aGilson (2015).

Note. SLB = street-level bureaucrat; SN = school nurse; SHE = sexual health education; LGBTQ = lesbian, gay, bisexual, transgender, and queer/questioning (one’s sexual or gender identity).

insufficient time in their schedules as school nurses (Hoekstra et al., 2016). With these limitations, school nurses were concerned about being evaluated on whether they had fulfilled the intent of the policy. Not having adequate resources encourages school staff to seek outside help to teach SHE, including groups outside of the school, to provide newer teaching materials, share responsibilities of delivery, and controversy about delivery could be more diluted (Dickson et al., in press). Not all school nurses are responsible for teaching SHE in their schools, as teaching staff are most

often the staff accountable for teaching health education content. However, the participants of this study shared a desire to implement SHE through the lens of their professional standards as they related to advocating for and providing health education (NASN, 2016, 2017b). However, the participants also found themselves having to abide by and be responsible to community in the context within which they work and (especially in rural communities) live.

Fewer than half of school nurse participants (46%) reported that state SHE policies were clear and

Table 3. Policy Actions and Strategies Identified by School Nurses to Successfully Enable Implementation of SHE Policy.

Strategy Type	Strategies
Policy priorities	Prioritize health and health education as important part of graduation requirements Hold local district and school accountable for state SHE policy requirements Offer resources so that SHE policy requirements are doable Consider existing workload of teachers and SNs when creating new policy requirements and allocate additional resources to support school staff
Policy language	Support state health and education agency collaboration for SHE policy oversight Clarify and mandate comprehensive SHE language in state policy Provide clear SHE policy language for school staff and assure their training, skills, and understanding of requirements
Support curricula development	Establish clear curriculum standards that align with state law Include SNs in curriculum and content review prior to establishing requirements Provide vetted SHE curriculum and resource lists for school staff and communicate information directly to health teachers and SNs (e-mail, newsletter, free resources) Require LGBTQ content in curriculum Allocate curriculum resources for schools to comply with stated state policy
Training, staff, and resources	Support additional training options including online learning for those responsible for SHE policy implementation (SNs and teachers) that do not require extensive travel Support certification or training for staff who teach SHE content, including teaching training for nurses and content training for teachers; SNs and teachers working together to implement SHE policy so that classroom messages can be further reinforced when the SNs provide clinical care Assure maintenance of qualifications and continuing education requirements for everyone who teaches SHE content in schools To gain school and community support for SHE, support orientation and training of school districts, school staff, and administrators on SHE content requirements (even if they are not directly responsible for teaching the content in classrooms) Assure that state agency representatives visit schools to better understand the support needed at the local school district level Monitor content and quality of the teaching at the local district, after appropriate training and resources are made available. Provide technical assistance support for schools trying to implement comprehensive SHE policy in communities that oppose such content Explicitly support inclusion of LGBTQ content in SHE curricula and provide appropriate training for staff responsible for teaching such content
Maintain/build budget for state health department	Strengthen health department budgets and critical health resources including access to reproductive health resources if SNs find that students need such services, for schools and students living in rural communities Support Department of Health public health nurses, enabling them to provide education and services for students if teachers and SNs are not able to teach SHE content. This could include establishing a formal memorandum of understanding and potential financial support for public health nurses, or at a minimum, for co-location of staff Develop staff speaker panel that are vetted and able to provide high-quality, evidence-based education

Note. SN = school nurse; SHE = sexual health education; LGBTQ = lesbian, gay, bisexual, transgender, and queer/questioning (one's sexual or gender identity).

understandable, and only a third reported the existence of a district-level policy to guide their work in teaching SHE content. Despite their responsibility to teach SHE content, the uncertainty of policy goals can undermine the work of school nurses who work directly with students and who are held accountable for student learning. Absence of clear policy language to direct implementation efforts is a frequent pattern within the work of SLBs (Gilson, 2015), and participants reported uncertain curriculum expectations, which increased barriers to teaching SHE. Noteworthy, school nurses in rural areas reported more often that they were clear about state policies (particularly about parental opt-out policies) and that they taught SHE more often than their urban counterparts. This might be because rural school nurses are

more isolated than urban nurses, do not have as many resources, or because there are less teaching staff available to teach SHE content. It is clear that additional research is needed to explore why. Rural school nurses also demonstrated a noticeable lack of ambiguity regarding SHE policy implementation, perhaps demonstrating a distinctive level of self-efficacy necessary to implement ambiguous policies, versus urban school settings where the potential ambivalence might be tolerated differently by the nurses and other staff in the school environment.

For many participants, many of the factors facilitating implementation and those factors identified as challenging the implementation of SHE policy were closely related. For example, school nurses reported that a positive relationship

with students made implementation of SHE policy easier, whereas difficult relationships with students or an “unsafe” school environment made implementation more of a challenge. Attitudes of community members and parents were another common pressure point. School nurses reported SHE implementation was less complicated when parents and community were supportive and were informed about the content of SHE. However, implementation was onerous and difficult when community members or parents were fearful or anxious about their children being taught SHE (Brewin et al., 2014). Cultural or language barriers and a lack of available health-care providers in the community also contributed to a challenging environment for implementation (Valenzuela-Yu, 2018). This might have reflected an underlying fear that actually teaching SHE would result in an increase of youth seeking reproductive health services versus concealing the issue or more specifically not confronting the fact that some students needed support long before the actual implementation of SHE. The fear of SHE causing youth to become sexually active has been disproved (Kirby, 2007), but common stereotypes remain among parents and school staff who might not be aware of the refuting evidence.

Cleaver and Rich (2005) found that school nurses often taught SHE content when teachers felt uncomfortable or were unwilling to teach sexual health topics. School nurses frequently navigate the tensions surrounding student sexual health (Borawski et al., 2015; Rasberry et al., 2015), directly engage school administration and staff about the subject matter (Maziarz, 2018), promote dialogue, listen to concerns and alleviate anxieties, and often are perceived as more appropriate professionals to deal with these topics (Brewin et al., 2014; Hayter et al., 2012; Hayter, Piercy, Massey, & Gregory, 2008). A positive, working relationship with teachers with clear communication, collaboration related to SHE, and inclusion in SHE planning and review (Borawski et al., 2015; Brewin et al., 2014; Klein, Sendall, Fleming, Lidstone, & Domocol, 2013) were reported by participants to help implementation. In contrast, a lack of communication or exclusion of school nurses from the planning process for SHE hindered implementation. This impact on implementation of SHE policy can be exacerbated when the policy is perceived as vague and unclear. While policy makers might seek vagueness in the policy language to allow for local interpretation of requirements, school nurses and teachers are left in a double bind, a dilemma in which they become more influenced by the organizational and community environments of the school and community than by their skills and professional knowledge about how best to meet the required policy and the needs of their students and school (Dickson et al., in press).

School nurses engaged their teaching role in classroom settings based on their previous experiences teaching, the level of support from teaching staff, support from administration for this part of their job, and the degree to which the school at which they worked prioritized health education in general and

SHE in particular (Borawski et al., 2015; Hoekstra et al., 2016; Klein et al., 2013). In their work with SHE, the school nurses frequently mentioned the importance of trust: with students, teachers, administrators, and parents. Participants believed a generally supportive environment enhanced that trust, resulting in easier implementation of SHE policy. Trust, as an important component of discretion for the SLB, includes professional and public trust to discern the importance of treating all equally, yet making reasonable and flexible decisions about how to implement policy (Gilson, 2015).

A key attribute of school nursing is advocacy: for student health, safe environments, accessible health services, educational funding, and assuring that all policies supporting healthy students in healthy environments are in place (Mazyck, Cellucci, & Largent, 2015; NASN, 2017b). School nurses, grounded in ethical and evidence-based practice, are leaders who bridge health care and education, provide care coordination, advocate for quality student-centered care, and collaborate to design systems that allow individuals and communities to develop their full potential (NASN, 2017b; Willgerodt, Brock, & Maughan, 2018). Not surprisingly, advocacy is also a fundamental characteristic of SLBs, who “use their knowledge, skill, and position to secure for clients the best treatment” (Lipsky, 2010, p. 72). School nurse participants shared multiple examples of how they advocate for SHE: working with district and school administration to support teaching resources to improve students’ access to SHE, clearly and professionally informing families and communities of the policy requirements, and as a result, improving the well-being and health of the students served. Given the breadth of these tasks and diversity of context, school nurses represent an underappreciated group of SLBs who influence and shape the educational opportunities to which communities are exposed, even in an area like SHE, which is controversial yet significantly impacts young people’s sexual decision-making and outcomes (Chin et al., 2012; Goesling, Colman, Trenholm, Terzian, & Moore, 2014; Lindberg & Maddow-Zimet, 2012).

When asked to identify specific support they and the schools in which they work needed from policy makers to implement SHE policy (Table 3), the school nurse participants confirmed how, as SLBs, their knowledge, experience, and position enabled them to advocate for their students, families, and schools. They articulated clear visions of collaboration between state health and education agencies to improve accountability for the implementation of SHE policy. They suggested this accountability and support for local schools and districts could positively affect the ability of teachers and nurses to implement SHE policy and could improve the lives of their students, providing an adequate resource allocation was in place to implement a clearly articulated policy. Several participants advocated for a SHE team model that incorporated the teaching expertise of educators and the health expertise of nurses to improve school

health, modeling collaboration at the local level (Brewin et al., 2014; Cheung et al., 2017).

School Nursing Implications

This study presents data that reflect the role that school nurses play in policy implementation, specifically regarding teaching and implementing SHE policy. While school nurses work within both health and education policy environments, they often are responsible for implementing policies of which they might not be fully aware (Dickson et al., in press).

Advocacy by school nurses has important implications for school health and educational policy (Raible et al., 2017). As professionals, school nurses draw on their clinical knowledge and expertise, knowledge of student health status, health education priorities, and existing policy requirements. As a result, nurses work to implement evidence-based interventions to improve SHE in the best interest of their students, for their success throughout their education and life (Maziarz, 2018; Rabbitte & Enriquez, 2019). The exercise of discretion by school nurses allows them to engage in policy implementation on the front lines in influential ways, despite limited resources in the school, in the classroom, and wherever decisions are made about what is taught in the SHE curriculum and how and by whom it is taught.

However, while this study has demonstrated the SLB role that school nurses play in SHE policy implementation, it begs the question of why is this role necessary? An unclear and ambiguous SHE policy demands the need for SLB discretion, of which school nurses have demonstrated they are qualified and capable. However, a clearly articulated and resource-supported SHE policy would increase the likelihood of implementation (Gardner & Brindis, 2017). The participants' suggestions to policy makers (Table 3) are places to start, to guide development and implementation of policies that more effectively support students, and orientation for nurses regarding the policy requirements. Clarification could also help the role of school nurses: Well-articulated policy is key in assuring the school nurse, as employees of their district and responsible to the policies of their organization and state, has the capacity and the authority to implement new initiatives. Implementation of school health policy is problematic without reasonably specific directives and expectations in state policy and without sufficient resources and training for staff (nurses, teachers) and orientation for families and community members involved in implementation efforts (Hampton Holland, Green, Alexander, & Phillips, 2016).

The important voice and story that school nurses have to share is critical in influencing policy at all levels, and their leadership can shape a school health policy that guides their practice (Bergren, 2017). The trusted voice of nurses (Brenan, 2018) as providers of SHE and as street-level policy implementers can contribute to the design of a SHE policy

that focuses on "creating conditions that facilitate quality and responsiveness in policy delivery" in the school environment (Brodin, 2012, p. 947).

Limitations

This small, descriptive study was conducted in only one state and included a convenience sample of school nurses who spoke from their experience. As such, we do not know how well the results can be generalized to other school nurse experiences or to other communities or states. The study was dependent upon the participants' opinions and what they disclosed about their experiences. While the participants self-selected to participate in the study, most participants were supportive of a comprehensive approach to SHE in secondary schools and did not support an abstinence-only-focused approach to SHE. Future research would benefit from a larger sample of school nurses, both rural and urban, as well as from the inclusion of perception about the school nurses' role in policy implementation from the perspective of their school staff and administration colleagues, as well as from policy makers. However, this was beyond the scope of this analysis, which attempted to assess the utility of this framework to school nurses.

Conclusion

School nurses, as SLBs, play an important role in policy implementation, to "close the gap between public promises made and performance" (Lipsky, 2010, p. 4) of health education policy in schools. School nurses are no stranger to the role of advocate for their students, schools, families, and the larger community, and policy advocacy is a logical extension of the patient-level advocacy that nurses assume (NASN, 2017b; Spenceley, Reutter, & Allen, 2006). With their skill and experience in advocacy, school nurses can lead policy discussions about the need for comprehensive SHE in schools. Just as school staff find themselves making policy in the classroom (Hohmann, 2016), school nurses can join their voices to speak to the importance of creating clear policies that incorporate the experience of those who are on the front lines of health and education policy delivery in schools and classrooms. In addition, they can speak knowledgeably about any disconnect between resources allocated versus resources needed to deliver SHE effectively.

Comprehensive SHE in school environments has been shown to positively affect adolescent health outcomes by decreasing risky sexual behaviors and by strengthening protective behaviors (Kirby & Laris, 2009). In addition, policies that clearly support comprehensive SHE in schools can positively influence the sexual health outcomes of adolescents such as reducing unintended pregnancy and sexually transmitted infections (Brindis & Moore, 2014). Yet, despite their role in providing health education, school nurses can often be overlooked as resources for education interventions, and their underrepresented view can be left out of vital policy

discussions (Brewin et al., 2014; Raible et al., 2017). As a bridge between health policy and education policy and based on their role as student advocates and street-level champions, the perspective of school nurses is critical for decision-making about how best to deliver SHE policy in their schools.

Acknowledgement

The authors would like to thank Mark Parshall, PhD, RN, FAAN for his valuable contributions to the development of this manuscript.

Author Contributions

Elizabeth Dickson contributed to conception or design, acquisition, analysis, or interpretation; drafted the manuscript; critically revised the manuscript; gave final approval; and agrees to be accountable for all aspects of work ensuring integrity and accuracy. Claire D. Brindis contributed to conception or design, acquisition, analysis, or interpretation; critically revised the manuscript; gave final approval; and agrees to be accountable for all aspects of work ensuring integrity and accuracy.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This project was supported by the Robert Wood Johnson Foundation Nursing and Health Policy Collaborative at the University of New Mexico, College of Nursing, and used the REDCap™ database, a program supported by the University of New Mexico's Clinical and Translational Science Center, National Institute of Health Grant #UL1TR001449. Dr. Brindis's time was partially supported by Grant #U45MC27709 from the Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau (Title V, Social Security Act), Division of Child, Adolescent and Family Health, Adolescent Health Branch (Adolescent and Young Adult Health National Resource Center: <http://nahic.ucsf.edu/resource-center/>).

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